PLEASE REFER TO INSTRUCTIONS ON ATTACHED COVER SHEET BEFORE COMPLETING FORM

EBD:

SPONSOR INFORMATION

1) **Sponsor's Name** **Last** **First** **MI** | 2) Sponsor's Social Security Number

3) Street or P.O. Box | Apt. No. | City | State | Zip Code

4) Sex M/F | 5) Birthdate **Mo** **Day** **Yr** | 6) Service Branch ❑USN ❑USMC ❑USPHS ❑Other (Specify) ❑US Army ❑USAF ❑USCG ❑NOAA

7) Sponsor's Phone Home ( ) Work ( ) Spouse Work ( ) | 8) Active Duty? ❑Yes ❑No

9) Active Duty Sponsor's Pay Grade ❑E1-E4 ❑E5 and Above | 10) Active Duty Unit of Assignment | 11) Rank | 12) Is sponsor an Active Duty Reservist? ❑Yes ❑No If yes, indicate separation date

13) Is sponsor: Deceased ❑Yes ❑No Retired ❑ Yes ❑No Enrolling ❑Yes ❑No | **If sponsor is deceased, skip to #20**

14) Sponsor's 1st Choice - Primary Care Manager ❑Team Name at Military Treatment Facility ❑Civilian Physician (if residence is not near an MTF)

15) List 1st Choice Primary Care Manager's Complete Address | 16) Is this your current physician? ❑Yes ❑No

17) Sponsor's 2nd Choice - Primary Care Manager ❑Team Name at Military Treatment Facility ❑Civilian Physician (if residence is not near an MTF)

18) List 2nd Choice Primary Care Manager's Complete Address | 19) Is this your current physician? ❑Yes ❑No

FAMILY MEMBER INFORMATION

20) **Name** **Last** **First** **MI** | **Relationship to Sponsor**

If spouse, are you retired from the military? ❑Yes ❑No | Social Security Number | Birthdate Mo Day Yr | Sex ❑Male ❑Female

Street or P.O. Box | Apt. No. | City | State | Zip Code | Phone ( )

Family Member's 1st Choice - Primary Care Manager ❑Team Name at Military Treatment Facility ❑Civilian Physician (if residence is not near an MTF)

List 1st Choice Primary Care Manager's Complete Address | Is this your current physician? ❑Yes ❑No

Family Member's 2nd Choice - Primary Care Manager ❑Team Name at Military Treatment Facility ❑Civilian Physician (if residence is not near an MTF)

List 2nd Choice Primary Care Manager's Complete Address | Is this your current physician? ❑Yes ❑No

Name **Last** **First** **MI** | **Relationship to Sponsor**

If spouse, are you retired from the military? ❑Yes ❑No | Social Security Number | Birthdate Mo Day Yr | Sex ❑Male ❑Female

Street or P.O. Box | Apt. No. | City | State | Zip Code | Phone ( )

Family Member's 1st Choice - Primary Care Manager ❑Team Name at Military Treatment Facility ❑Civilian Physician (if residence is not near an MTF)

List 1st Choice Primary Care Manager's Complete Address | Is this your current physician? ❑Yes ❑No

Family Member's 2nd Choice - Primary Care Manager ❑Team Name at Military Treatment Facility ❑Civilian Physician (if residence is not near an MTF)

List 2nd Choice Primary Care Manager's Complete Address | Is this your current physician? ❑Yes ❑No

OTHER

21) Have all non-active duty beneficiaries, age 17 or older, completed a Health Enrollment and Assessment Review (HEAR) form? ❑Yes ❑No

23) Other Health Insurance (OHI)

Policy Number: _____

Insurance Company Name: _____

Effective Dates: From_____To_____ Type of Coverage ❑Family ❑Individual

Policy Type: ❑Champus Supplemental ❑Commercial ❑Employer GRP

Policy Holder Name: _____ (Last) (First) (Middle)

Policy Holder SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Patient Name: _____ (Last) (First) (Middle)

Relationship to Insured: ❑Spouse ❑Former Spouse ❑Child

Pharmacy: ❑Yes ❑No

Do you currently have Medicare benefits? If so, please indicate the effective date of coverage and what coverage you have:

Medicare Part A ❑ Yes ❑ No Effective Date _____

Medicare Part B ❑ Yes ❑ No Effective Date _____

22)Fee Information (MUST PAY FEE AT TIME OF ENROLLING)

Payment Option

Annual Enrollment:
❑**Active Duty** None
❑**Individual** $230.00
❑**Family** $460.00

Quarterly Enrollment:
❑**Active Duty** None
❑**Individual** $57.50
❑**Family** $115.00

Amount Enclosed: $ _____

Method of Payment

❑Personal Check* No._____ ❑Cashiers Check No. _____

❑Traveler's Check No._____ ❑Money Order No. _____

Type of card ❑Visa ❑MasterCard ❑American Express ❑Discover

Credit card number [ ][ ][ ][ ] - [ ][ ][ ][ ] - [ ][ ][ ][ ] - [ ][ ][ ][ ] Expiration Date _____

Your signature authorizes the credit card company to charge the card number above.

Signature _____

*There is a returned check fee.

24) Are you or any family member requesting enrollment participating in the Program For Persons With Disabilities (PFPWD)? ❑Yes ❑No

If yes, please list participants:

25) Where did you receive your enrollment form?
❑ Mailed to you by SMHS ❑ Picked up at a briefing ❑ Picked up at a TRICARE Service Center ❑ Picked up at a Military Treatment Facility

ACKNOWLEDGMENT

26) **I have read the information on benefits and restrictions of the TRICARE Prime program provided me.** I understand the restrictions as stated or explained to me and hereby apply for enrollment. I understand that I must choose a Primary Care Manager (PCM) participating in TRICARE Prime or select a military hospital, clinic or dispensary, when available, as my Primary Care Site to be covered by the Plan. If I decide to obtain care which has not been coordinated by my PCM and authorized by a Health Care Finder, or seek services from a non-TRICARE Prime provider, I understand that TRICARE Prime coverage will not apply and I will be responsible for payment under the Point-of-Service option for all services received. I understand that I must pay an initial and annual non-refundable enrollment fee if the sponsor is retired/deceased. I understand that enrollment is subject to verification of funds. I understand I must remain enrolled in TRICARE Prime for 12 consecutive months. I understand that my entitlement to TRICARE benefits will be confirmed through the Defense Enrollment Eligibility Reporting System (DEERS). I authorize the Plan to obtain, examine, disclose and copy records of any physician, hospital or provider when necessary for proper payment of benefits for all enrollees listed on this document; this form serves as Medical Records Release. Aphotographic copy of this authorization shall be as valid as the original. I hereby certify that the information provided on this document is true and complete. I agree to abide by the provisions of membership. I must disenroll from TRICARE Prime when I am no longer eligible or move from the TRICARE Prime regions. The Plan will not discriminate, or have the effect of discriminating, against any beneficiaries on the basis of health status, age, race, sex, family size, sponsor status or sponsor rank. I understand that I may be asked to waive travel access standards to seek medical treatment.

I UNDERSTAND ENROLLMENT FEES ARE NOT REFUNDABLE.
Please review the Agency Disclosure and the Privacy Act on the attached cover sheet before using.

Signature _____ Relationship to Sponsor _____ Date _____

AUTHORITY: 10 U.S.C. Chapter 55 CHAMPUS PRINCIPAL PURPOSES: Enrollment in the TRICARE Prime program. ROUTINE USES: Verify eligibility and produce enrollment cards. DISCLOSURE IS VOLUNTARY. Failure to provide the information could result in denial of reimbursement under the CHAMPUS program.

White Copy – Return to SMHS **Yellow Copy – Keep for your records**

TRICARE PRIME ENROLLMENT FORM INSTRUCTIONS

Thank you for choosing TRICARE Prime. Please print all information in ink and fill out the form accurately and completely. Your application will be delayed if your family information is incomplete or does not match the DEERS file. If you are unsure of how to answer a question, please call our toll-free telephone number 1-888-999-5195. Our Beneficiary Services Representatives will be happy to assist you.

1-12. Self-explanatory

13. Is Sponsor Deceased, Retired, Enrolling - Check appropriate box. Even if sponsor is deceased, you must complete sections 1-12.
    Note: If sponsor and spouse are both retired from the military and plan to enroll additional family members in TRICARE Prime, you must visit the local personnel office to have a family medical record created under one social security number.

Important:
Return White copy in enclosed envelope. The Yellow copy should be retained as proof of intent to enroll. Enrollment is subject to eligibility, Primary Care Manager assignment and all other TRICARE regulations. Upon completion of the enrollment process, a Prime identification card will be mailed to you. In the meantime, please use yellow copy.

14. If sponsor lives 30 minutes or 20 miles from a Military Treatment Facility (MTF), list the Team Name for the Primary Care Manager; if the sponsor does not live near an MTF, choose a civilian provider from the Provider Directory and list for the Primary Care Manager. Note that some physicians' practices are full and they will only accept patients that they have seen before. If unclear, call 1-888-999-5195 and speak with Enrollment.
15. List Military Treatment Facility team address or Primary Care Manager's Address, City, State, Zip Code.
16. Indicate whether the physician you have chosen is your current physician - Check the appropriate box.
17. List Sponsor's second choice for a Primary Care Manager (Military Treatment Facility team or civilian Primary Care Manager) from the Directory. A Military Treatment Facility team or a civilian physician MUST be selected from your TRICARE Provider Directory.
18. List second choice of Military Treatment Facility team address or Primary Care Manager's Address, City, State, Zip Code.
19. Indicate whether the physician you have chosen is your current physician - Check the appropriate box.
20. Family Member information - List information for all family members who are enrolling in the TRICARE Prime program. MUST select Primary Care Manager to enroll. Please state two (2) Primary Care Manager choices for each Prime member. SMHS will assign a Primary Care Manager if your first and second choice cannot be honored. If enrolling more than two (2) family members, use another form.
21. Have all beneficiaries, age 17 and older, completed a Health Enrollment and Assessment Review form (HEAR)? Check the appropriate box.
22. Billing options. Retirees and their family members wishing to enroll in Prime must pay an annual enrollment fee. Please state whether you would like to pay annually or quarterly - Check the appropriate box. Please indicate amount enclosed or to be charged.

	ENROLLMENTFEES
ACTIVE DUTY FAMILY MEMBERS None	RETIREES AND THEIR FAMILIES Individual: $230 annually or $57.50 per quarter Family: $460 annually or $115 per quarter

Method of payment - Check the appropriate box. All enrollment fees must be paid at the time of initial enrollment into TRICARE Prime. If paying by credit card, signature required. Make Checks Payable To: SMHS, Inc. There is a returned check fee. Please refer to the TRICARE Provider Directory for guidance on Primary Care Manager selection in your planning area. Sierra Military Health Services, Inc. will assign a Primary Care Manager if your first and second choice cannot be honored. Please mail your application and appropriate enrollment fee to the following address: Sierra Military Health Services, Inc., P.O. Box 956, Baltimore, MD 21203-0956.

23. Does the Sponsor or eligible Family Members have other health insurance coverage, including Medicare?
24. Are you or any family members requesting enrollment participating in the Program For Persons With Disabilities(PFPWD)?
25. Specify the last time the Sponsor or family member used CHAMPUS, not including the Military Treatment Facility - Check the appropriate box.
26. Read the acknowledgement. Sign and date application form and indicate relationship to sponsor.

Your completed application form will be processed, and a Prime enrollment card will be mailed to each eligible family member. The effective date of membership will be indicated on each card.

AGENCY DISCLOSURE STATEMENT: Public reporting of this collection of information is estimated to average 15 minutes per application, including the time for reviewing instructions, searching existing date sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to the Department of Defense, to Washington Headquarters Services, Directorate of Information Operations and Reports, 1216 Jefferson Davis Highway, Suite 1204, Arlington, VA 92202-4802; and the Office of Management and Budget, Paperwork Reduction Project 0720-0008, Washington DC 20508. PLEASE DO NOT RETURN YOUR ENROLLMENT APPLICATION TO EITHER OF THESE ADDRESSES. SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION SHEET.

PRIVACYACTSTATEMENT: (1) 44 USC 8101; 10 USC 1079 and 1086, 38 USC 613; EO 9397. (2) Purpose: To evaluate for medical care provided by civilian sources to Military Health System beneficiaries applying for coverage under the TRICARE Program (82 CFR, Part 199.17). (3) Uses: Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS): to the Department of Justice for representation of the Secretary of Defense in civil actions: and to Congressional Offices in response to inquiries made in the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program. (4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.